Get Ready: Preparing for Integration in Post Acute Care

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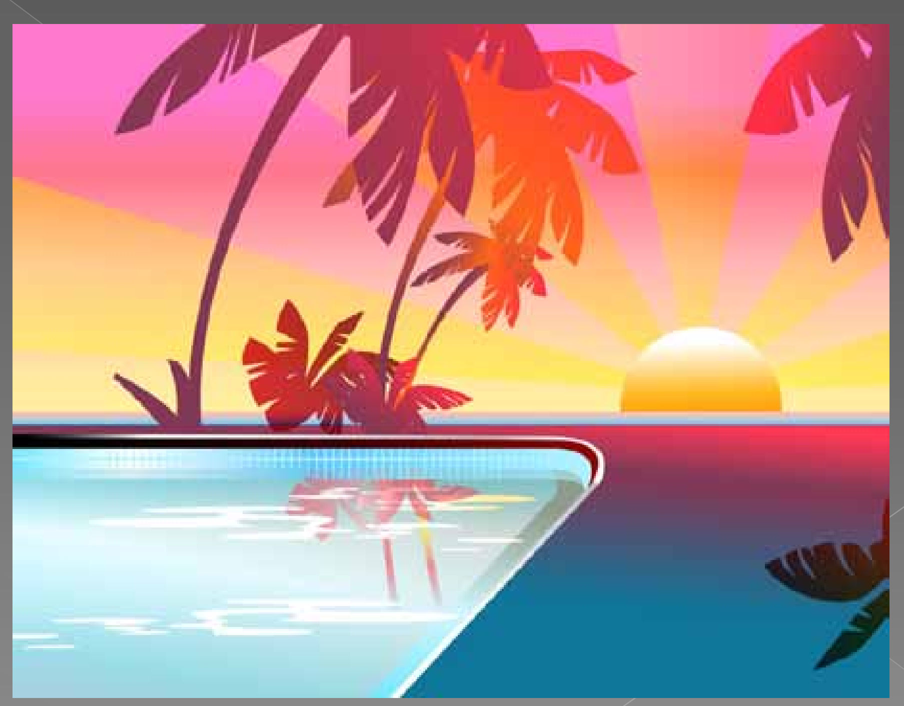
The Current landscape

The Post Acute Continuum:

- IRF's
- SNF's
- LTACH's
- HHA's
- OP ?



Our reality

Post acute payment system challenges

- Different level of care have different payment systems
- There is no uniform assessment instrument which provides for data analysis of efficacy of care

Payment systems

Table 2
Prospective Payment Systems for Post-acute Care

Feature	**Skilled Nursing Facilities (SNF-PPS)**	**Inpatient Rehabilitation Facilities (IRF-PPS)**	**Long-term Care Hospitals (LTCH-PPS)**	**Home Health Agencies (HHA-PPS)**
Unit basis	Per-diem*	Per case/ per hospitalization	Per case/ per hospitalization	Per 60-day episode of care
Case-mix adjuster	Resource Utilization Groups III (RUGs III)	Function-related groups (FRGs) or case-mix groups (CMGs)	Diagnosis-related groups (DRG's) specific to LTCH patients	Home Health Resource Groups (HHRCs)
No. of case-mix groups	53	92 CMGs X 4 Co-morbidity subgroups/CMG= 368 groups	540	153
Input document/ information Source	Minimum Data Set MDS+	Patient Assessment Instrument (IRF-PAI)	IDC-9-CM codes recorded on pt claims	Outcome & Assessment Information Set (OASIS)

*Based on assessments made on the 5th, 14th, 30th, 60th and 90th days after admission to a SNF.
+ The MDS is completed on the 5th, 14th, 30th, 60th, and 90th days after admission to a SNF.
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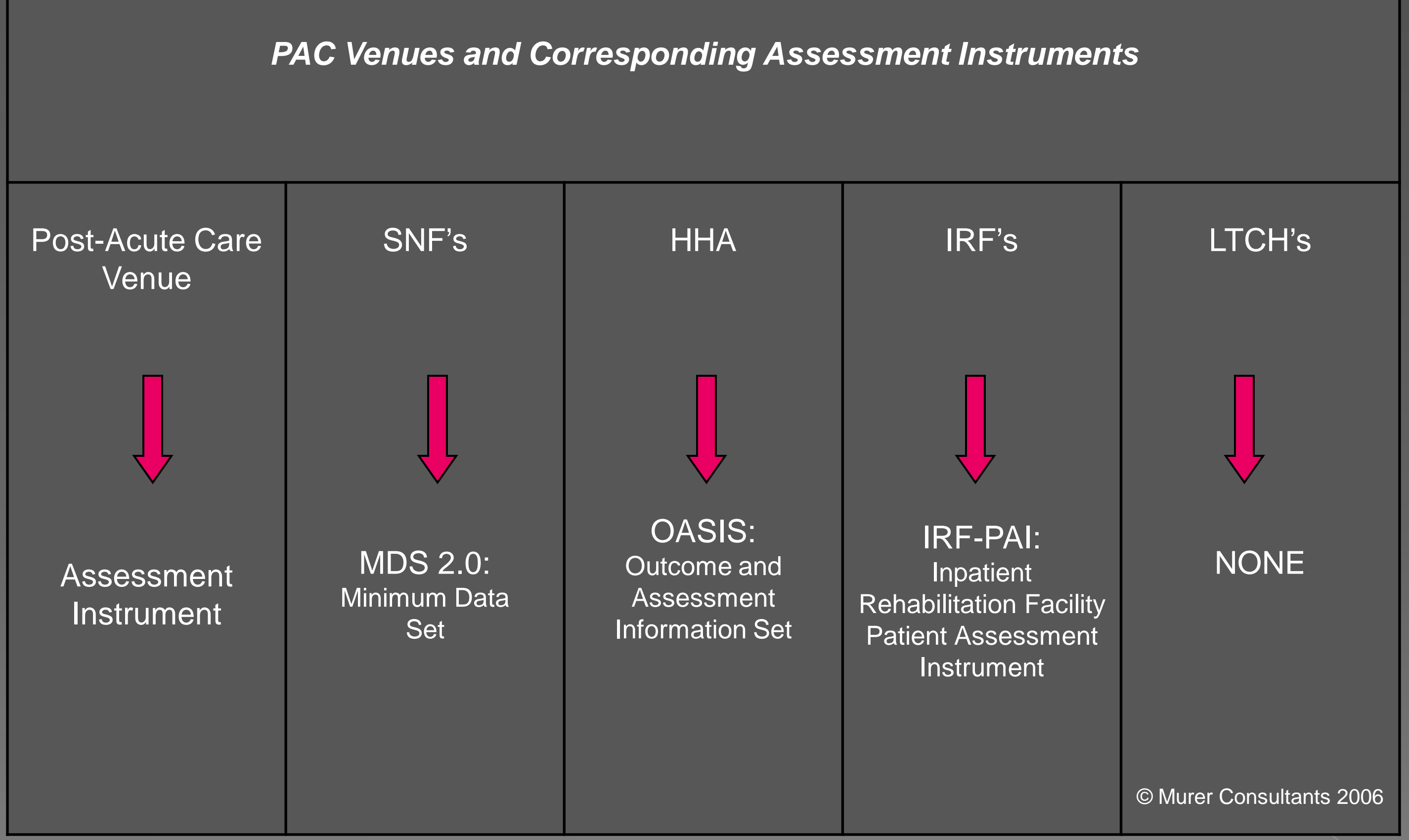
Today's post acute assessment instruments



PAC Venues and Corresponding Assessment Instruments				
Post-Acute Care Venue	SNF's	HHA	IRF's	LTCH's
↓	↓	↓	↓	↓
Assessment Instrument	MDS 2.0: Minimum Data Set	OASIS: Outcome and Assessment Information Set	IRF-PAI: Inpatient Rehabilitation Facility Patient Assessment Instrument	NONE

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Change exercise

Change Readiness Assessment

1. The executives in the company are:

   Satisfied with the way things are now — Dissatisfied, but not overly concerned about the present state — Very dissatisfied with the present state of the company

   1 2 3 4 5 6 7 8 9 10

2. The sponsor or champions of change:

   Has not been identified or has low respect and is distrusted by the organization — Is somewhat respected and trusted by the organization — Is highly respected and trusted by the organization

   1 2 3 4 5 6 7 8 9 10

3. Teamwork:

   Is rarely demonstrated because people work very independently — Is demonstrated during special projects and in areas that are highly interdependent — Is highly valued and demonstrated at all levels

   1 2 3 4 5 6 7 8 9 10

4. Leaders in this organization:

   Are opposed to providing the people and resources necessary to successfully implement changes — Are reluctant to provide the people and resources that are necessary to successfully implement changes — Are willing to provide the people and resources that are necessary to successfully implement changes

   1 2 3 4 5 6 7 8 9 10

5. If we do not change, we are likely to:

   Maintain financial and market share position — Experience some financial difficulties or loss of market share — Experience severe financial difficulties or loss of market share

   1 2 3 4 5 6 7 8 9 10

6. Key people in the organization are seen as:

   Weak advocates or resistors of change — Mild advocates of change — Strong advocates of change

   1 2 3 4 5 6 7 8 9 10

Developed by The Renova Corporation www.renovacorp.com

Health Care Reform: New Payment Approaches

- 2011: Center for Medicare and Medicaid innovation
  - Hospital Acquired Conditions
  - Establishment of community based transition program to the highest cost Medicare beneficiaries
- 2012:
  - Reducing avoidable hospital admissions
  - Demonstration Project: bundled payment
  - Demonstration: Home-based primary care teams
- 2013:
  - Bundled payment pilot
  - Improved patient accuracy OASIS
- 2014:
  - Independent payment advisory board

2011: Reform Begins

- Significant care delivery system reforms:
  - Chronic Care management
  - Transitions in care
  - Accountable Care organizations
  - Post acute care bundling
  - Performance-based payment

Health Care Reform: Transitions in Care

- Re-hospitalization prevention and avoidance
- Who will your ACO (Accountable Care Organizations) be:
  - Hospital is the customer: bundling base?
  - Community-based ACO model?
  - Physician practice based ACO model?
- Select discharge monitoring and oversight

ACO Models

- Fee for service plus bonus
- Bundled payment plus bonus
- Global capitation plus bonus
- Partial capitation
- Shared savings

Patient-centeredness

- The primary focus of CMS′ vision for post-acute care is for the system to become patient-centered. In other words, the system will be organized around an individual beneficiary′s needs rather than around the settings where care is delivered. This vision defines post-acute care in terms of patient populations needing care. Specifically, post-acute care is care that is provided to individuals who need further support to assist in recuperation following an acute illness of serious medical procedure.
- -The Patient-Centered Vision for Post-Acute Care Reform; Cherilyn G. Murer, JD, CRA

Elements of Patient-Centered Post Acute Care

- Optimization of Choice and Control of Services
- Placement decisions based on patient needs with both the patient and family receiving honest and useful information about the patient's situation and prognosis
- Coordinated, high quality care with seamless transitions between settings
- Rewarding excellence by reflecting performance on quality measures in payment
- Recognizing the critical role of family care-giving
- And
- Utilizing health information technology

- -The Patient-Centered Vision for Post-Acute Care Reform; Cherilyn G. Murer, JD, CRA

Post-acute bundling

- One payer per episode of care
- Goal: decrease re-hospitalizations
- Hospitals/ACO's pay for post acute services

What does bundling look like?

Key questions:

Payment per episode of care?
V.
Payment per episode of post-acute care?

Timeline on episode of care windows?

Are OP services in or out of post-acute continuum? Does OP include MD as well as therapy services?

Selection of patient assessment tool?

So what exactly are we bundling?

- Post acute services
- Acute and post acute services
- Acute, post acute and physician services

Late-breaking news…

- **CMS announced ACA bundled payment demonstration** (from AHA News*Now* - August 23, 2011)
- "Doctors, hospitals and other health care providers can apply to participate in a Medicare demonstration that will bundle payment for an episode of inpatient and/or post-acute care in an effort to better coordinate care for patients and reduce costs, CMS announced … The Patient Protection and Affordable Care Act demonstration offers applicants four approaches to bundled payments, three involving a retrospective payment arrangement with a target price for a defined episode of care and one involving a single prospective payment for all services furnished during an inpatient stay. The first retrospective arrangement defines the episode of care as the inpatient stay in a general acute-care hospital; the second as an inpatient stay plus 30-90 days of post-acute care; and the third as 30 or more days of post-acute care. Organizations must submit a letter of intent by Sept. 22 for payment model 1 and Nov. 4 for payment models 2, 3 and 4…"
- More information including fact sheets and applications for the Center for Medicare and Medicaid Innovation demonstration can be found on the Center for Medicare and Medicaid Innovations site at www.innovations.cms.gov. A copy of the HHS press release can be viewed at http://www.hhs.gov/news/press/2011pres/08/20110823a.html . A copy of the Frequently Asked Questions is attached.

Looking ahead at Quality Indicators

THE WALL STREET JOURNAL.

WSJ.com

JUNE 7, 2011

Don't Come Back, Hospitals Say

Hospitals push to reduce the 4.4 million preventable hospital re-admissions a year.

By LAURA LANDRO

Medicare Rehospitalization Costs $17 Billion a Year

Posted by MedHeadlines in Health Insurance | 15 comments

As many as 20% of all Medicare patients released from a hospital will be readmitted again within 30 days. These ... readmissions are often the result of missed or inadequate follow-up care recommended upon release from ... hospitalization. Rehospitalization, as these unplanned ... medical conditions, and ...

Medicare News

Health Law Forces Changes to Reduce Hospital Readmissions of Medicare Patients

Transitional Care May Cut Hospital Readmission Rates

Intervention programs for discharged seniors might even save health-care dollars, one doctor suggests

Hospital data looks at patient satisfaction, deaths, readmissions

BrightStar's BrightInsights

Current Articles | RSS Feed

Homecare and Avoiding Hospital Re-Admission

Posted by Erin Schmidt on Tue, Aug 10, 2010 @ 01:14 PM

We've written about hospital infection rates before, indicating that sepsis and pneumonia killed 48,000 patients and added $8.1 billion to health care costs in 2006 alone. And a current news story about famous 93-year-old Hungarian actress Zsa Zsa Gabor making headlines illustrates this tragic circumstance we see all too often, as she has developed an infection while in the hospital after having surgery on a broken hip.

Medicare data shows that nearly 1 in 5 patients who leave the hospital are re-admitted within the next month and that even more than 75% of these re-admissions are preventable. The top reasons for 30-day hospital re-admissions?

http://www.wakemed.org/body.cfm?xyzpdqabc=0&id=1512&action=detail&ref=39913 8/26/2011

Recommended Reading

- Center for Post-acute Studies (2009). Bundling Payment for Post-acute Care: Building Blocks and Policy Options. Washington, DC: National Rehabilitation Hospital.
- Available at:

www.postacuteconference.org

Exercise

- How ready are you and your organization for change?
- What questions do I have: shout it out!

Visioning

- What do I look like today?
- What will I need to look like in 3 years?
- What do I need to do between now and then to prepare?

Needs and Gap Analysis: Define your ideal post acute continuum

EXAMPLE Today	1-Year	3-Year
Continuum lacks SNF element	Restructuring reporting models to consolidate post acute services under one executive	Partnership for SNF services
Silo'd post acute elements	Enhancement of post-acute liaison role to cover ALL levels of post acute care; cross training of staff; one point of access	Integrated financial, quality and patient outcomes reporting

EXERCISE

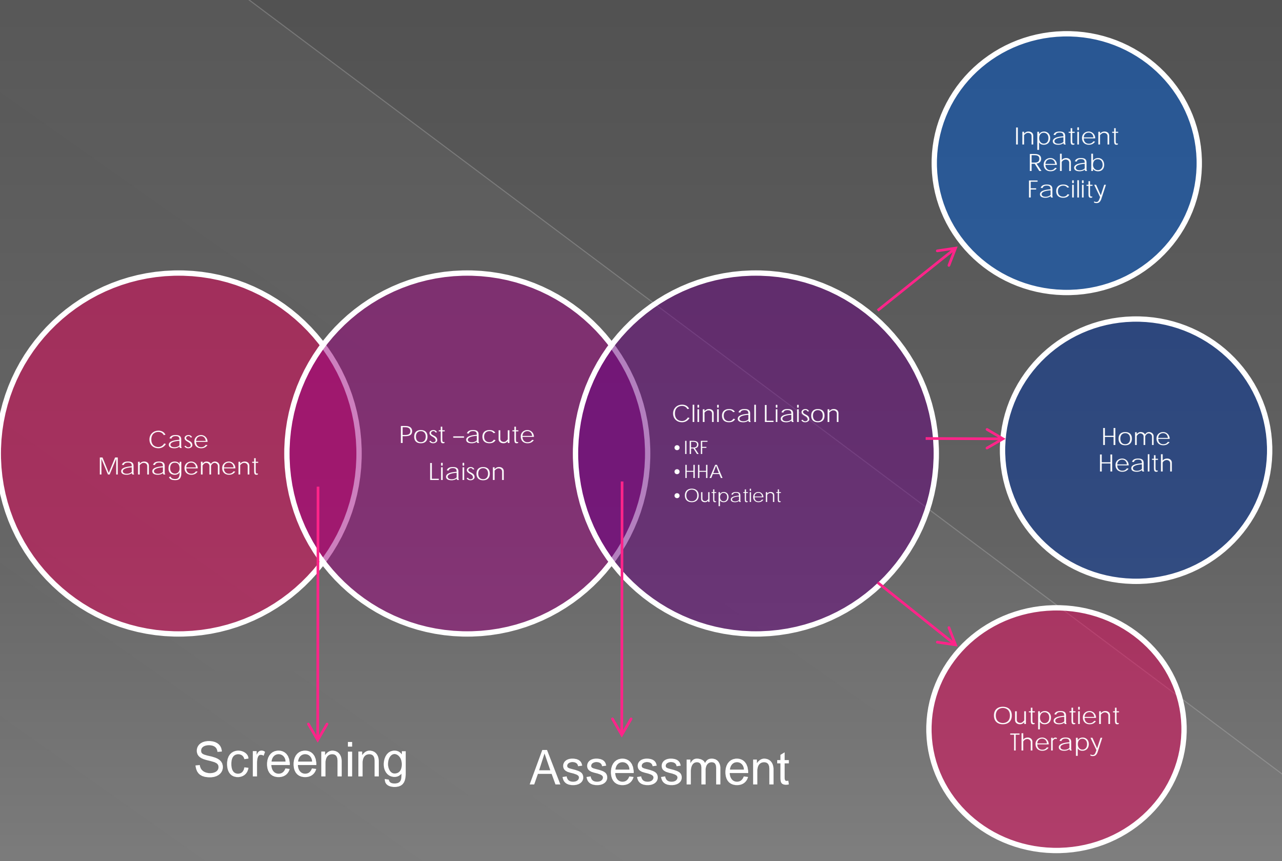
- On your hand-out:
- Think about your setting
  - Draft a current state
  - Draft a 3-year desired state
- Consider the action steps today, at 1 year and at 2 year that will get you to your desired state
  - Write these on the provided Post-It
  - Find the TODAY, 1-year and 2-Year posters on the wall and post your action steps
- Write your name and e-mail on the sign-in sheet
- We'll share the action steps with ALL so you can benefit from others' perspectives as well.

Operational Opportunities

Operational steps we're taking today:

- Organizational structure
- Who's on the work team
- Single point of access
- System for screening all admissions/Integrated patient identification process
- Algorithms and crosswalks
- Cross training
- Joint marketing and patient education opportunities

Our Model



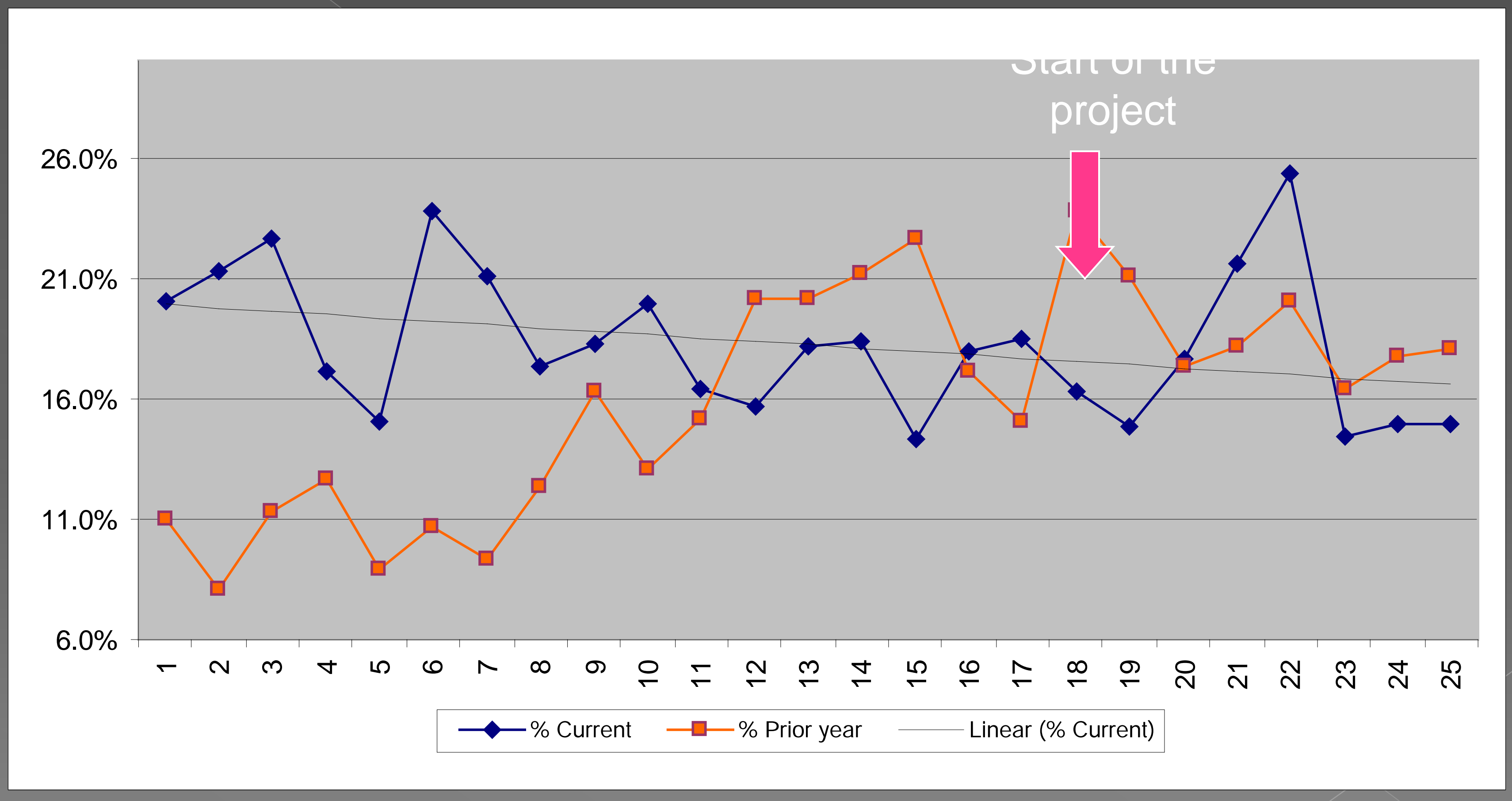
The potential of case management

- Where does it sit within the organization?
- What is your relationship today? What will it be tomorrow? From the silo to the patient centered
- Today: d/c planning with timeliness of IP DC as key measure
- Tomorrow: care planning along a continuum with patient outcomes as central measure
- Pediatric care management example

Post acute liaison role

- Identification of patients AT ADMISSION who will need post-acute services.
- Ensuring patient choice is maintained.
- Engage clinical liaisons in assessment as appropriate and ordered by physician
- Track and monitor patient transitions, including readmissions.
- Primary point of inquiry/access regarding post acute services.

Impact of model on HC Referrals



Telehealth

- Allows us to monitor the a patient seven days a week
- We have taken long term chronic patients and transitioned them home, and kept them home beyond the 30 days
- Fits nicely with an acute care approach, meaning that the patient can be receiving both home care and outpatient services

Potential Benefits

- Identification and referral of post acute continuum patients
- Algorithms to drive level of care decisions
- Increased admissions
- Decreased readmissions
- Returning patients to community/independent living status

While some things change, some remain the same

Shands Rehab Hospital mission statement:

Help families and individuals challenged by physical and cognitive disabilities return to community life.

Questions?

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